# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10726

## CERTIFICATE OF DEATH

10693

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Lee Middle Blackburn Last
4. DATE OF DEATH Month Oct Day 19 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept 1886
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY Ship yard
11. BIRTHPLACE (State or foreign country) Ash Co. N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 233-22-0739
17. INFORMANT Address Mrs Lee Blackburn Darlington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis Darlington Md
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH Unknown
Coop

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1947, to Oct, 1957, that I last saw the deceased alive on Oct 12 1957, and that death occurred at 1 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Dudley Phillips MD M.D. ADDRESS (Street, city or town, state) Darlington Md DATE SIGNED
PHYSICIAN'S NAME (Type) Dudley Phillips MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF Oct 20 1957
22c. NAME OF CEMETERY OR CREMATORY Baptist Home
22d. LOCATION (City, town, or county) (State) Wilson Co N. C.

23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey ADDRESS Darlington Md
24a. REC'D BY REGISTRAR DATE Oct 21 1957
24b. REGISTRAR'S SIGNATURE C. H. Kirk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

## CERTIFICATE OF DEATH

10694

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 1½ DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRYVILLE 07x2.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle AMELIA Last BOULDEN

4. DATE OF DEATH: Month OCTOBER Day 6 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1879

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY GALLION

14. MOTHER'S MAIDEN NAME: AURILLA WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Florence L. Boulden — Address: Perryville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis
576x
DUE TO
(b): Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 1½ days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 4th, 1957, to Oct. 6th, 1957, that I last saw the deceased alive on Oct. 6th, 1957, and that death occurred at 3.31 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Foo M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave. — DATE SIGNED: 10/6/57

PHYSICIAN'S NAME (Type): Edward C. Foo, M.D. — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-8-1957

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson Son — ADDRESS: Perryville, Md.

24a. REC'D BY REGISTRAR DATE: 10-8-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Local Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

.10694 — 10695

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Bel Air
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sturgill's, RD1 Bel Air

3. NAME OF DECEASED (Type or print): First Donnie Middle E. Lost Brinegar

4. DATE OF DEATH: Month October Day 10 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 26, 1957

9. AGE (In years last birthday): IF UNDER 1 YEAR Months — Days 14; IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Sparta N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Gladys Brinegar

14. MOTHER'S MAIDEN NAME: Frances Crouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Gladys Brinegar — Address: 1340 PONTIAC AVE. BALTIMORE 25, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: -

391.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Otitis Media

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congenital heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-10-57 Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 11 57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Salem Cemetery

22d. LOCATION (City, town, or county) (State): Sparta N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Foster — ADDRESS: Broadway + Williams Streets Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: 10-11-57

24b. REGISTRAR'S SIGNATURE: Priscilla Foxwood

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10695

Reg. Dist. No. 10696 / 183

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haure de Grace 24
d. STREET ADDRESS: 512 Lewis St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Marshall — Middle: James — Last: Carter

4. DATE OF DEATH: Month: Oct — Day: 17 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15, 1889

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (State or foreign country): N.C

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Carter

14. MOTHER'S MAIDEN NAME: Meekie Nealy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 237-14-0190

17. INFORMANT: Jennie Carter — Address 512 Lewis St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral apoplexia
DUE TO
334 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension
DUE TO
(c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 16, 1957 to Oct. 17, 1957, that I last saw the deceased alive on Oct 17, 1957, and that death occurred at 9:20 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D Hirsch M.D. — ADDRESS (Street, city or town, state): 421 Congress Ave. Havre de Grace — DATE SIGNED

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH — 421 CONGRESS AVE. - HAVRE DE GRACE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Oct. 20, 1957

22c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

22d. LOCATION (City, town, or county): Salisbury (State): N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock, Havre de Grace, Md. — ADDRESS: 556 Lewis St.

24a. REC'D BY REGISTRAR DATE: 10-20-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10727

10697

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 182

**1. PLACE OF DEATH**

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Convalescent Home

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street Rural

STREET ADDRESS (If rural give location)

**3. NAME OF DECEASED** (Type or Print) (First) Ogello (Middle) (Last) Chamberlain

**4. DATE OF DEATH** (Month) October (Day) 3 (Year) 1957

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Jan. 31, 1881 | 76 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife At Home | | Harford Co. Md. | U.S.A |

13. FATHER'S NAME Columbus Scarborough

14. MOTHER'S MAIDEN NAME Mary Scarborough

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| No | No | No | Mrs. Jessie E. Scarborough Street Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X IMMEDIATE CAUSE (A) Carcinoma of the transverse colon — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) None

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from July 1, 1957, to October 2, 1957, that I last saw the deceased alive on October 1, 1957, and that death occurred at ..... M, from the causes and on the date stated above.

| SIGNATURE | | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|---|
| Willard P. Hudson | M.D. | Forest Hill Md | 10/3/57 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 6, 1957 | Emory Cem | Harford Co. Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| Oct. 5, 1957 | C.A. Kirk | H.S. Bailey | Harlington Md |

1

FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10696 10698

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4
d. STREET ADDRESS: E 25th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle T Last Cint

4. DATE OF DEATH: Month October Day 20 Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 6, 1922

9. AGE (In years last birthday): 35 yrs.

IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Crib Att.,

10b. KIND OF BUSINESS OR INDUSTRY: Bendix Radio

11. BIRTHPLACE (State or foreign country): Champaign, Ill.,

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Virgil Cint

14. MOTHER'S MAIDEN NAME: Mildred ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 347-12-9081

17. INFORMANT (Address): Viola Cint, 35 E.,25th St., Baltimore,Md,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture skull, compound, comminuted
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto-auto type

20c. TIME OF INJURY: Hour 1205 a.m. Month, Day, Year 10-20 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): US Route 40

20f. (City or town) Edgewood (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ Md.
EXAMINER'S NAME (Type): Gerald E Palmer MD
DATE SIGNED: 10-20-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Oct. 20, 1957
22c. NAME OF CEMETERY OR CREMATORY: Owens Funeral Home,
22d. LOCATION (City, town, or county) (State): Champaign, Champaign, Ill.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas, Jr. ADDRESS: Abingdon, Md.
24a. REC'D BY REGISTRAR DATE: OCT 23 1957
24b. REGISTRAR'S SIGNATURE: Dr. A. L. Lewis

Howard K. Mc Comas & Son

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10697

## CERTIFICATE OF DEATH

Reg. Dist. No. 10699 185

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b 3 DAYS 9 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMRIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle WILEY Last COX

4. DATE OF DEATH Month OCTOBER Day 21 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH DEC 21 1900

9. AGE (In years last birthday) 56 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY STORE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME WILLIAM DAVID COX

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address ZOLA E. COX (WIFE) WHITE HALL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertension Arteriosclerosis — 1 year

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16, 1957 to 10/20, 1957 that I last saw the deceased alive on 10/20, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Irvin Wachsman, M.D. ADDRESS (Street, city or town, state) 407 S. Union Ave DATE SIGNED 10/21/57

PHYSICIAN'S NAME (Type) IRVIN WACHSMAN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-23-57

22c. NAME OF CEMETERY OR CREMATORY NEW BETHEL BAPTIST

22d. LOCATION (City, town, or county) (State) HOPEWELL TWP. YORK Co. PA.

23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W Cochran ADDRESS Stewartstown, Penna.

24a. REC'D BY REGISTRAR DATE OCT 25 1957

24b. REGISTRAR'S SIGNATURE Dr. A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10728

10700

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE RI
d. STREET ADDRESS: RD #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 10 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D. #2

3. NAME OF DECEASED (Type or print): First JAMES — Middle M. — Last DE BONIS

4. DATE OF DEATH: Month Oct — Day 7 — Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 1, 1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK DE BONIS
14. MOTHER'S MAIDEN NAME: ELIZABETH UNK.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: PEARL H. DE BONIS
Address: HAVRE DE GRACE, RD. #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — Yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. / p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954 to 10/7 1957, that I last saw the deceased alive on 10/1 1957, and that death occurred at 8:55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F.V. Hatem, M.D. — ADDRESS (Street, city or town, state): Aberdeen, Md — DATE SIGNED: 10/8/57

PHYSICIAN'S NAME (Type): F.V. Hatem — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 11, 1957
22c. NAME OF CEMETERY OR CREMATORY: BEL AIR MEMORIAL GARDENS
22d. LOCATION (City, town, or county) (State): BEL AIR, MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md
24a. REC'D BY REGISTRAR DATE: 10-11-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698 10701

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 722 GREEN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAVRE DE GRACE
d. STREET ADDRESS 1722 GREEN, ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CARROLL Middle WATTS Last DENNIS
4. DATE OF DEATH Month Oct Day 31 Year 1957

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH SEPT. 26 1882
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY RETIRED
11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME DENNIS
14. MOTHER'S MAIDEN NAME ALICE MITCHELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address
Mrs. ANNA ARMSTRONG HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema. — INTERVAL BETWEEN ONSET AND DEATH 1h
420.0
DUE TO (b) Arteriosclerotic Heart Disease — 9m
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
26ox Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1956, to Oct. 31, 1957, that I last saw the deceased alive on 10/24, 1957, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE J. J. Haten M.D. ADDRESS (Street, city or town, state) 17 N. Phila. Rd. Aberdeen Md. DATE SIGNED 11/1/57
PHYSICIAN'S NAME (Type) F. J. Haten Aberdeen - Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Nov. 2 1957
22c. NAME OF CEMETERY OR CREMATORY ROCK RUN
22d. LOCATION (City, town, or county) HARFORD (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE 11-4-57
24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729

10702

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belcamp Rural

c. LENGTH OF STAY IN 1b: Lifetime

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ ~~Aberdeen~~ Rural Belcamp

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS: Harford Furnace

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Charles Middle Edward Last Dickson

4. DATE OF DEATH: Month Oct. Day 8, Year 1957

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 25, 1871

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David Dickson

14. MOTHER'S MAIDEN NAME: Nancy Kerr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Robert Dickson, Address: Bel Air R.D., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma Lung - Sudden metastasis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1952, to Oct, 1957, that I last saw the deceased alive on Oct 7, 1957, and that death occurred at 6 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN'S NAME (Type): J. Ralph Harky M.D.

ADDRESS (Street, city or town, state): Churchville

DATE SIGNED: Oct 10

Churchville Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 11, 1957

22c. NAME OF CEMETERY OR CREMATORY: St. Francis

22d. LOCATION (City, town, or county) (State): Abingdon, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas Jr.

ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 11, 1957

24b. REGISTRAR'S SIGNATURE: Norma B. Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10730

## CERTIFICATE OF DEATH

10703

Reg. Dist. No. 180

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Joppa
c. LENGTH OF STAY IN 1b: 2 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reckord Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Joppa
d. STREET ADDRESS: Reckord Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Charles Middle M. Last Diven

4. DATE OF DEATH: Month October Day 24 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 1, 1884

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith.

10b. KIND OF BUSINESS OR INDUSTRY: Blacksmithing

11. BIRTHPLACE (State or foreign country): Balto. Co., Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas H. Diven

14. MOTHER'S MAIDEN NAME: A. Mary Resh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Andrew Mazer
Address: Joppa, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Thrombosis (3rd) — 3 days
DUE TO (c): Hypertensive Cardiovas. Dis — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/13, 1933, to 10/24, 1957, that I last saw the deceased alive on 10/23, 1957, and that death occurred at 10:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford F. Hudson M.D.
ADDRESS (Street, city or town, state): Fork, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON, FORK, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 27, 1957
22c. NAME OF CEMETERY OR CREMATORY: Emanuel Cemetery
22d. LOCATION (City, town, or county) (State): Glen Rock, Pa. R.D.

23. FUNERAL DIRECTOR'S SIGNATURE: Jacob Hartenstein
ADDRESS: New Freedom, Pa.

24a. REC'D BY REGISTRAR DATE: NOV 1 1957

24b. REGISTRAR'S SIGNATURE: Norma Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

10731

10704

Reg. Dist. No. 18

**1. PLACE OF DEATH**

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) High Point Road

LENGTH OF STAY (in this place) 9 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Md COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) High Point Road

STREET ADDRESS (If rural give location) Forest Hill Md

**3. NAME OF DECEASED** (Type or Print) (First) LESSIE (Middle) JANE (Last) DUNCAN

**4. DATE OF DEATH** (Month) Oct (Day) 19 (Year) 1957

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 11 01 14 1896 | 61 yrs. | 11 | 9 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | VOX · N.C. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Calvin Cheek | ENNICE Johnson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| NO | 215-32-9685 | Franklin M Duncan Forest Hill Md |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) CONGESTIVE HEART FAILURE — OVER 1 YR

DUE TO (C) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE — OVER 1 YR

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from MAY, 19 57, to OCT 19, 19 57, that I last saw the deceased alive on OCT 13, 19 57, and that death occurred at 3:40 P.M, from the causes and on the date stated above.

**SIGNATURE** Philip W. Hausman M.D. **ADDRESS** (Street, city, town, state) 307 HICKORY BEL AIR, Md **DATE SIGNED** OCT 19, 1957

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 22-57 | Bel Air Mem. Gardens | Bel Air Md. |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10-22-57 | Priscilla Fawood | Martin E Kurtz | Jarrettsville Md |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10699 10705

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 13HRS 23MIN.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ~~Harford~~ Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN. 07 x 0.2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frank Middle Edwin Lost ECCLES

4. DATE OF DEATH: Month OCTOBER Day 25 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 25, 1957

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 13 Min. 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT WILLIAM ECCLES

14. MOTHER'S MAIDEN NAME: BEATRICE DAILY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 776x Prematurity — Immat.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/25, 1957 to 10/25, 1957, that I last saw the deceased alive on 10/25 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. ADDRESS (Street, city or town, state): Rising Sun, Md DATE SIGNED: 10/25/57

PHYSICIAN'S NAME (Type): Neil Taylor Jr. Rising Sun - Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): 10-25-57

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL HOSPITAL

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry R. Tilley Administrator ADDRESS

24a. REC'D BY REGISTRAR DATE 11-1-57

24b. REGISTRAR'S SIGNATURE: G. L. Lewis M.D.

207 234 X V2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/SS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700 10706

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Bel Air.
d. STREET ADDRESS 1 R.D #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Hannah Middle Ellen Last Everitt
4. DATE OF DEATH Month 10 Day 6 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 5 1888
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Iris George
14. MOTHER'S MAIDEN NAME Estelle Patterson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Wm P Everitt Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
420.1
DUE TO (b) Arteriosclerosis Generalized — 3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
URINARY INCONTINENCE, TUMOUR of U. BLADDER
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 19 53 to Oct 6th 19 57, that I last saw the deceased alive on Oct 6th 19 57, and that death occurred at 3:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE A. Sandecki M.D. M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct 8/57
22c. NAME OF CEMETERY OR CREMATORY St Margs Episcopal
22d. LOCATION (City, town, or county) (State) Emmorton Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE Joseph T Feeley
ADDRESS Bel Air Md
24a. REC'D BY REGISTRAR DATE OCT 9 1957
24b. REGISTRAR'S SIGNATURE R. A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10707 185

Reg. Dist. No.

10701

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit 07x22
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith Middle A. Last Ewing
4. DATE OF DEATH: Month October Day 17 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-9-02
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: Crippled
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Elie Ewing
14. MOTHER'S MAIDEN NAME: Lena May Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Ruth Martin — Address: Port Deposit Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetes Mellitus -- uncontrolled. — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
260 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 14, 1957 to Oct 17, 1957, that I last saw the deceased alive on Oct. 17, 1957, and that death occurred at 1 o'clock P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 10/18/57
PHYSICIAN'S NAME (Type): Neil Taylor Jr — Rising Sun, Md — 10/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 20/57
22c. NAME OF CEMETERY OR CREMATORY: Hopewell Cem
22d. LOCATION (City, town, or county) (State): Rising Sun Md

23. FUNERAL DIRECTOR'S SIGNATURE: L. Earl Tipton — ADDRESS: Rising Sun Md
24a. REC'D BY REGISTRAR DATE: OCT 21 1957
24b. REGISTRAR'S SIGNATURE: Dr. A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10702 — 10708 — Reg. Dist. No. 185

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 24
d. STREET ADDRESS: 815 Erie
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chester — Middle: — Last: Faltynowicz
4. DATE OF DEATH: Month: October — Day: 19 — Year: 19 57

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/20/1917
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Curtain Runner
10b. KIND OF BUSINESS OR INDUSTRY: APG
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Faltynowicz
14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): W.W. 2 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs Theresa Faltynowicz — Address: Pulpit & Elizabeth St. Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Poisoning by Carbon Monoxide
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Piped auto exhaust fumes into his car
20c. TIME OF INJURY: Hour 1 a.m. p.m. — Month, Day, Year: 10-19 19 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Garage
20f. (City or town) Havre de Grace (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer (MD)
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
Bel Air Md
DATE SIGNED: 10-19-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/22/57
22c. NAME OF CEMETERY OR CREMATORY: Mt Erin
22d. LOCATION (City, town, or county) Havre de Grace (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros. — ADDRESS: Havre de Grace Md
24a. REC'D BY REGISTRAR DATE: 10-24-57
24b. REGISTRAR'S SIGNATURE: A L. Lewis M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 8M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703 **CERTIFICATE OF DEATH** Reg. Dist. No. 10705

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 2 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY: LANCASTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PEACH BOTTOM — RURAL
d. STREET ADDRESS: 75 X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JERRY — Middle WAYNE — Last FLORA

4. DATE OF DEATH: Month OCTOBER — Day 30 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-22-1955

9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Lancaster Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Franklin Flora

14. MOTHER'S MAIDEN NAME: Maxine Geneva Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: David F. Flora — Address: Peach Bottom, Penn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Tracheolaryngobronchitis — INTERVAL BETWEEN ONSET AND DEATH: 7 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/29, 1957 to 10/30, 1957, that I last saw the deceased alive on 10/30 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor Jr. M.D. — ADDRESS (Street, city or town, state): Rising Sun — DATE SIGNED: 10/31/57

PHYSICIAN'S NAME (Type): Neil Taylor Jr. — Rising Sun Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov 3 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Penn Hill Cem — 22d. LOCATION (City, town, or county) (State): Quarryville Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Earl Tyson — ADDRESS: Rising Sun Md

24a. REC'D BY REGISTRAR — DATE: NOV 4 1957

24b. REGISTRAR'S SIGNATURE: Dr. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10732

Reg. Dist. No. 10719 / 8 / 1

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman ×2
d. STREET ADDRESS Witherspoon's Trailer Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William — Middle C. — Last Foreman
4. DATE OF DEATH: Month October — Day 7 — Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/7/1943
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert C. Foreman
14. MOTHER'S MAIDEN NAME: Lillian M. Hammel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): G.S.W. R. chest
919.0
DUE TO (b):
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Accidently Shot with shot-gun
20c. TIME OF INJURY: Hour 5 p. m. — Month, Day, Year 10-7-1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Perryman (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Bel Air Md
DATE SIGNED 10-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/1957
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) Bel Air (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Harvey
ADDRESS: Aberdeen Md.
24a. REC'D BY REGISTRAR DATE: Oct 11-57
24b. REGISTRAR'S SIGNATURE: Nellie R. Perry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Local Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10704 — 10711 — Reg. Dist. No. 183

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 Y01. 4
d. STREET ADDRESS: Fox Holabird
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: E — Last: Gardner

4. DATE OF DEATH: Month: October — Day: 20 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/19/1925

9. AGE (In years last birthday): 32 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: USA

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Unknown.

14. MOTHER'S MAIDEN NAME: Clara (Unknown).

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): Current

16. SOCIAL SECURITY NO.: 145-18-0663

17. INFORMANT: Address: Quarter Master Dept. A.P.G. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

816X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident, auto - auto type

20c. TIME OF INJURY: Hour o. m. — Month, Day, Year: 10 - 20 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): US Route 40

20f. (City or town) Edgewood (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C. Palmer MD

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-20-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 10/22/1957
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) Franklin (State) New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Carring — ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: 10.24.57
24b. REGISTRAR'S SIGNATURE: A L. Lewis M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10705 — Reg. Dist. No. 10712

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dot Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 1603 N. Stokes
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ronald — Middle: Spencer — Last: Grieninger
4. DATE OF DEATH: Month: October — Day: 9 — Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-18-39
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lyell Ed. Grieninger
14. MOTHER'S MAIDEN NAME: Mildred Steiner Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-36-4733
17. INFORMANT — Address: Lyell E. Grieninger, Havre de Grace, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull, compound — INTERVAL BETWEEN ONSET AND DEATH:
816x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture R leg.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto-object collision
20c. TIME OF INJURY — Hour: 5 p. m. — Month, Day, Year: 10-9-57
20d. INJURY OCCURRED — While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): R155+0 away — 20f. (City or town): Havre de Grace (County): (State): Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — Bel Air Md — DATE SIGNED: 10-9-57
EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 13, 1957
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill
22d. LOCATION (City, town, or county): Havre de Grace (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md
24a. REC'D BY REGISTRAR — DATE: 10-14-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10706

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10713

Item 7 FilmG222 10-29-57 et

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bare de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Aberdeen Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO [illegible] RD. 2 Bel Air
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Clifford Franklin Middle Hash Last
4. DATE OF DEATH: Month October Day 19 Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-19-39
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Building & Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Glenn Hash
14. MOTHER'S MAIDEN NAME: Mary Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Glenn Hash Address R.D. 2 Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull, comminuted, compound.
819 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture both bones L. leg
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto - object type
20c. TIME OF INJURY: Hour 3 p. m. Month, Day, Year 10-18 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bush X
20f. (City or town) Pylesville (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Bel Air, Md 10-(8-57

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/21/57
22c. NAME OF CEMETERY OR CREMATORY: Welcome Home Cemetery
22d. LOCATION (City, town, or county) (State): R.D. Bel Air Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Harring
ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: 10-24-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10714

10733

# CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magnolia
c. LENGTH OF STAY IN 1b: 5 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Magnolia
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: G. — Last: Hueitt

4. DATE OF DEATH: Month: Oct. — Day: 10, — Year: 1957

5. SEX: male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 26, 1891

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elisha Elisiah Hueitt

14. MOTHER'S MAIDEN NAME: Hannah Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Samule K. Hueitt, Joppa R.D., Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thromosis — INTERVAL BETWEEN ONSET AND DEATH: several hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease — many years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Possible nephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 11 19 56, to October 10, 19 57, that I last saw the deceased alive on October 1, 19 57, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul S. Stonesifer Jr. M.D. — ADDRESS (Street, city or town, state): 115 Fulford Ave. — DATE SIGNED: 10/12/57

PHYSICIAN'S NAME (Type): Paul S. Stonesifer, Jr. — Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove
22d. LOCATION (City, town, or county) (State): Rocks, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard McInnis Jr. — ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 14, 1957

24b. REGISTRAR'S SIGNATURE: Norma G. Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

00

1

I

-0

0

2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

10707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 31
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #2 Buchanan Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 12 Buchanan Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: E — Last: Johnson
4. DATE OF DEATH: Month: October — Day: 10 — Year: 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 31 March 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-&-Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Hardware Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Johnson
14. MOTHER'S MAIDEN NAME: Katherine Holloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-09-9069
17. INFORMANT: Mrs. Arthur E. Johnson — Address: 2 Buchanan Ave. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: —
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Yeor 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autapsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Belair Md.
DATE SIGNED: 10-11-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/13/57
22c. NAME OF CEMETERY OR CREMATORY: Spesutia
22d. LOCATION (City, town, or county) (State): Aberdeen, R.D. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garrney
ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: Oct 13/57
24b. REGISTRAR'S SIGNATURE: Nellie R. Perry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708

## CERTIFICATE OF DEATH

Reg. Dist. No. 10716

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen

c. LENGTH OF STAY IN 1b: 11 year

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace

d. STREET ADDRESS: 401 S. Union Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: Elgar — Last: King

4. DATE OF DEATH: Month: October — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 21, 1917

9. AGE (In years last birthday): 40 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John King

14. MOTHER'S MAIDEN NAME: Iva Heaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 446-01-01379

17. INFORMANT — Address: Official Army Records, APGm Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable acute coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 2, 1957, to October 2, 1957, that I last saw the deceased alive on October 2, 1957, and that death occurred at 1105a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William M. Michener M.D.

ADDRESS (Street, city or town, state): US Army Hospital Aberdeen Proving Ground, Md.

DATE SIGNED: Oct 2, 1957

PHYSICIAN'S NAME (Type): WILLIAM M MICHENER, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 10/4/57

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State): Kaufer Texas

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garring — ADDRESS: Aberdeen md.

24a. REC'D BY REGISTRAR DATE: Oct 4-57

24b. REGISTRAR'S SIGNATURE: Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709 ~~10711~~ 10717

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Penna — b. COUNTY: Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Peach bottom 75 x 3
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nina — Middle: V. — Last: Knight
4. DATE OF DEATH: Month: October — Day: 2 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2-27-1896
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Orr
14. MOTHER'S MAIDEN NAME: Mary E. Sampson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: J. Graham Knight — Address: Peach Bottom, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours.
DUE TO (b): and Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 422.1
DUE TO (c): Arteriosclerotic Cardiovascular disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 29th, 1957, to Oct. 2nd, 1957, that I last saw the deceased alive on October 2, 1957, and that death occurred at 8:52 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward C. Toon, M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave. — DATE SIGNED: 10/2/57
PHYSICIAN'S NAME (Type): Edward C. Too, M.D. — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-5-1957
22c. NAME OF CEMETERY OR CREMATORY: Darlington
22d. LOCATION (City, town, or county) (State): Darlington, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Vida A. Patterson & Son — ADDRESS: Perryville, Md
24a. REC'D BY REGISTRAR DATE: 10-3-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6 FilmG222 11-4-57 et

10710

## CERTIFICATE OF DEATH

Reg. Dist. No. 10718

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 626 Brenda Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 626 Brenda Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: W. — Last: Kollmar

4. DATE OF DEATH: Month: October — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 17 March 1919

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Analyist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Walter H. Kollmar

14. MOTHER'S MAIDEN NAME: Frieda Jungermann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2, Korean

16. SOCIAL SECURITY NO.: 145-03-4100

17. INFORMANT: Joshua Kramer — Address: Aberdeen, Md.

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, abdominal — INTERVAL BETWEEN ONSET AND DEATH: 4 months
199.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 29, 1957, to Oct 24, 1957, that I last saw the deceased alive on Oct 24, 1957, and that death occurred at 10:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: B. J. Plunkett Jr. M.D.
ADDRESS (Street, city or town, state): 617 W. Bel Air Ave.
DATE SIGNED: Oct 25, 1957

PHYSICIAN'S NAME (Type): B.J. Plunkett Jr. M.D. — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10/28/57
22c. NAME OF CEMETERY OR CREMATORY: Greenmount
22d. LOCATION (City, town, or county): Baltimore (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Fanning
ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: Oct 28/57
24b. REGISTRAR'S SIGNATURE: Nellie R. Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10711 10719

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b 24 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 411 Edmund Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS 411 Edmund St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Joseph Middle E. Last Lawson

4. DATE OF DEATH Month 10 Day 3 Year 1957

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 3-27-1897

9. AGE (In years last birthday) 60 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber

10b. KIND OF BUSINESS OR INDUSTRY Barber

11. BIRTHPLACE (State or foreign country) Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Charles Lawson

14. MOTHER'S MAIDEN NAME Isabell Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Mrs. Mary E. Lawson - Aberdeen, Md. Address 411 Edmund St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH 6 weeks
DUE TO (b) Carcinoma of prostate — 5 years
DUE TO (c)

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-2, 1957, to 10-3, 1957, that I last saw the deceased alive on 10-2, 1957, and that death occurred at 5:15 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE B. J. Plunkett Jr. M.D. ADDRESS (Street, city or town, state) Aberdeen Md DATE SIGNED 10-4-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-8-1957

22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery

22d. LOCATION (City, town, or county) Aberdeen (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Otelia J. Bullock - Harvey Grace Md. ADDRESS 556 Lewis St.

24a. REC'D BY REGISTRAR DATE Oct 5 57

24b. REGISTRAR'S SIGNATURE Nellie R. Berry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10712

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10720

Reg. Dist. No. 182

**1. PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 336 Catherine St

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Mich
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Detroit 59K-3
d. STREET ADDRESS: 8051 CAHALAN St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Charles — Middle: Herbert — Last: Lovell

**4. DATE OF DEATH**: Month: October — Day: 4 — Year: 1957

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: MARCH 10, 1886

**9. AGE** (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): RETIRED

**10b. KIND OF BUSINESS OR INDUSTRY**: TRAIN CONTROL INSPECTOR AND ~~CONDUCTOR~~

**11. BIRTHPLACE** (State or foreign country): LONDON, ENGLAND

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: UNKNOWN LOVELL

**14. MOTHER'S MAIDEN NAME**: ELIZABETH GARD

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): —
(If yes, give war or dates of service): —

**16. SOCIAL SECURITY NO.**: —

**17. INFORMANT**: S. EVERET LOVELL — Address: 336 CATHERINE St. BEL AIR, Md.

## MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour: o. m. / p. m. — Month, Day, Year: 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-4-57

**22a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**22b. DATE THEREOF**: OCT. 8, 1957
**22c. NAME OF CEMETERY OR CREMATORY**: WOODMERE CEMETERY
**22d. LOCATION** (City, town, or county) (State): DETROIT, MICH.

**23. FUNERAL DIRECTOR'S SIGNATURE**: Joseph Foster
ADDRESS: BROADWAY AND WILLIAMS Sts. BEL AIR, MD.

**24a. REC'D BY REGISTRAR** DATE: 10-5-57
**24b. REGISTRAR'S SIGNATURE**: Priscilla Harwood

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10734 10721

# CERTIFICATE OF DEATH

Reg. Dist. No.....

**1. PLACE OF DEATH**

COUNTY HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL

LENGTH OF STAY (in this place) 4 WEEKS

HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD CONVALESCENT HOME

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE MD COUNTY HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE,

STREET ADDRESS (If rural give location) 224 N. STOKES ST.

**3. NAME OF DECEASED** (Type or Print) (First) WALTER (Middle) (Last) OSBORNE

**4. DATE OF DEATH** (Month) (Day) (Year) OCTOBER 7 1957

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WH | MARRIED | 1/11/1884 | 73 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED CARPENTER | UNK | SWAN CREEK | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WILLIAM DAVIS OSBORN | VIRGINIA MITCHELL |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| NO | NO | UNK | VIRGINIA WILSON R.D. Aberdeen Md. |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 422.1 | IMMEDIATE CAUSE | (A) Lobar Pneumonia, bilateral, ~~Atypical~~ Hypostatic | 5 days |
| | ANTECEDENT CAUSE(S) DUE TO | (B) Terminating Cerebral thrombosis (Oct. 2, 1957) | |
| | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | (C) Chr. Cardio-Vascular Disease | |

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Duodenal ulcer — ?

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from Sept. 23, 1957, to Oct. 8, 1957, that I last saw the deceased alive on Oct. 6, 1957, and that death occurred at 11:40 M, from the causes and on the date stated above.

| SIGNATURE | | ADDRESS (Street, city, town, state) | DATE SIGNED |
|---|---|---|---|
| Willard P. Hudson | M.D. | Forest Hill Maryland | 10-7-57 |

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/10/57 | PRESBYTERIAN, | CHURCHVILLE Md |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| 10-9-57 | Priscilla Fawwood | Pennington & Son Havre de Grace Md | |

RECEIVED

OCT 11 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

## CERTIFICATE OF DEATH

Reg. Dist. No. 10722 85

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORT DEPOSIT, RURAL
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First IRA — Middle S — Last POIST

4. DATE OF DEATH: Month OCTOBER — Day 29 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-18-1894

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWNER

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George H. Poist

14. MOTHER'S MAIDEN NAME: Emma A. Nicols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-24-2509

17. INFORMANT: 215 Frank S. Poist — Address: Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
DUE TO
422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chr. Nephritis —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956 to Oct 29, 1957, that I last saw the deceased alive on Oct 29, 1957, and that death occurred at 4:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I Benson — M.D.
ADDRESS (Street, city or town, state): Port Depost,
DATE SIGNED: 10/30/57

PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D. — Port Deposit Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-31-1957
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham
22d. LOCATION (City, town, or county) (State): Colora, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son, Perryville, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE: 10-31-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10723

# CERTIFICATE OF DEATH

10714

Reg. Dist. No. 182

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

LENGTH OF STAY (in this place): 5 Years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Harford Convalescent Home

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air

STREET ADDRESS (If rural give location): 1

**3. NAME OF DECEASED** (Type or Print): Annie (First) M. (Middle) Purcell (Last)

**4. DATE OF DEATH**: October (Month) 10 (Day) 1957 (Year)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | August 2, 1867 | 90 yrs. | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawrence Purcell

14. MOTHER'S MAIDEN NAME: Annie Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Dora Johnson, Bel Air, Md.

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491x IMMEDIATE CAUSE (A) Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Upper respiratory infection DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

**22. I hereby certify** that I attended the deceased from 11/15, 1950, to October 10 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

SIGNATURE: Willard P. Hudson M.D. ADDRESS (Street, city, town, state): Forest Hill, Md. DATE SIGNED: October 11, 1957

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1957 October 12 | St. Ignatius | Hickory, Harf. Co., Md. |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
|---|---|---|---|
| DATE 10-11-57 | Priscilla Forwood | Joseph W. Foster | Broadway & Williams Sts. Bel Air, Maryland |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

## CERTIFICATE OF DEATH

10724 Reg. Dist. No. 781

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) aberdeen
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Balto Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen.
d. STREET ADDRESS 111 Balto Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Grove Middle Watson Last Robson
4. DATE OF DEATH Month Oct Day 22 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Dec 5th 1882
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Self Emp. Carpenter
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Robson
14. MOTHER'S MAIDEN NAME Ella Bond.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-03-5530
17. INFORMANT Address Allen B. Robson aberdeen md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral thrombosis — 3 months
DUE TO (c) Cerebral & generalized arteriosclerosis — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 8, 1957, to Oct 22, 1957, that I last saw the deceased alive on Oct 22, 1957, and that death occurred at 10:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE B. J. Plunkett Jr. M.D. ADDRESS (Street, city or town, state) 617 W. Belair Ave DATE SIGNED 10-23-57

PHYSICIAN'S NAME (Type) B.J. Plunkett Jr. M.D. Aberdeen, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF 10/24/57
22c. NAME OF CEMETERY OR CREMATORY Seneca Cemetery
22d. LOCATION (City, town, or county) (State) Stanley New York

23. FUNERAL DIRECTOR'S SIGNATURE John T. Garvey ADDRESS aberdeen maryland.
24a. REC'D BY REGISTRAR DATE Oct 24/57
24b. REGISTRAR'S SIGNATURE Nellie R Perry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1

Item 21 Film 222 11-15-57 ams

10725

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

10716

Reg. Dist. No. 182

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**1. PLACE OF DEATH**

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

LENGTH OF STAY (in this place): 54 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Md — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air Rural

STREET ADDRESS (If rural give location): RD 1

**3. NAME OF DECEASED** (Type or Print): (First) Rebecca (Middle) G (Last) Ruff

**4. DATE OF DEATH**: (Month) Oct (Day) 26 (Year) 1957

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Feby 1875 | 82 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | King George Co Va | US |

13. FATHER'S NAME: Benj F Grymes

14. MOTHER'S MAIDEN NAME: Rebecca Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| | | | Henry Ruff Bel Air RD 1 |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

903.0 IMMEDIATE CAUSE (A) CARDIO-RESP FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 10 MIN.

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) PULMONARY EDEMA — 30 MIN

DUE TO (C) SHOCK IN 82 YR OLD CONGESTIVE — 1 HOUR

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. FAILURE PATIENT FROM BROKEN HIP-AT

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | Home | Rural Bel Air Harford Md. |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED While at work ☐ Not while at work ☒ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| Oct 26 57 P.M. | | Fell on bedroom floor - apparently tripped over rug. |

**22. I hereby certify** that I attended the deceased from ..., 19 55, to 26 Oct, 19 57, that I last saw the deceased alive on 26 Oct, 19 57, and that death occurred at 11:30 P.M, from the causes and on the date stated above.

SIGNATURE AND M.D.: W H Antwell — ADDRESS (Street, city, town, state): Bel Air. Md — DATE SIGNED: 28 Oct 57

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 29-57 | Watters Meeting House | Thomas Run Rd Harford Md |

| 24. REC'D BY REGISTRAR DATE | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| 10-28-57 | Priscilla Foxwood | Joseph T Foster Bel Air Md |

FOR STATE HEALTH DEPT.

10717

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10726

Reg. Dist. No. 187

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Country Life Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Country Life Farm
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: A — Last: Ryan

4. DATE OF DEATH: Month: October — Day: 19 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 20, 1891

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Commodore Merchant Service

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Ryan

14. MOTHER'S MAIDEN NAME: Agnes Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Chrales A. Ryan Marylander Apts

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: —

163x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer MD

Bel Air, Md. — DATE SIGNED: 10-19-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/23/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. W. Mears & Son 825 N. Calvert St.

24a. RECD BY REGISTRAR — DATE: OCT 21 1957

24b. REGISTRAR'S SIGNATURE: Pauline Towers

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10718 10727

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY ~~Harford~~ Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3Vol-4 ~~Darlington~~ Baldwin Md
d. STREET ADDRESS Plaza Apts- Perkwilson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Florence Middle P Last Sadtler
4. DATE OF DEATH Month October Day 19 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov-15-1869
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME George T. Sadtler
14. MOTHER'S MAIDEN NAME Ann S. Platt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address Ann H. Wilson. Darlington, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH 2 hours
443x
DUE TO (b) Hypertensive cardio vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
Rectal polyp

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 7, 1957, to October 19, 1957, that I last saw the deceased alive on October 19, 1957, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James McC. Finney M.D. ADDRESS (Street, city or town, state) 330 S. UNION AVE, Havre de Grace, Md. DATE SIGNED Oct. 19, 1957

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct 21 '57
22c. NAME OF CEMETERY OR CREMATORY Green Mount
22d. LOCATION (City, town, or county) (State) Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE Stewart Mortuary ADDRESS 1218 York Balto
24a. REC'D BY REGISTRAR DATE OCT 22 1957
24b. REGISTRAR'S SIGNATURE Dr. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10719

10728

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: HARFORD

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE

c. LENGTH OF STAY IN 1b: 7 HRS 55 MIN

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITEFORD X2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA Middle BELLE Last SEYMOUR

4. DATE OF DEATH: Month OCTOBER Day 7 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 13, 1887

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM REED

14. MOTHER'S MAIDEN NAME: LETTIE DOLLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: ELSIE HARDING Address: STREET, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis — 3 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/6, 1957, to 10/7, 1957, that I last saw the deceased alive on 10/7, 1957, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. ADDRESS (Street, city or town, state): Rising Sun, Md. DATE SIGNED: 10/8/57

PHYSICIAN'S NAME (Type): Neil Taylor Jr Rising Sun, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-9-57

22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d. LOCATION (City, town, or county) (State): DELTA, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Habbina ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: 10-9-57

24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10720

10729

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Edgewood

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
d. STREET ADDRESS: Box 118
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony Middle: Estes Last: SILVEIRA
4. DATE OF DEATH: Month: October Day: 21 Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1897
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Business Manager
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Portugal
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silveira, Anthony A.
14. MOTHER'S MAIDEN NAME: Francisca da Gloria Vargas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-20-7893
17. INFORMANT: Georgia I. Silveira, Address: Edgewood, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Hypertensive Cardiovascular Disease — ?
DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 11th, 1957 to Oct. 21, 1957 that I last saw the deceased alive on Oct. 21st., 1957, and that death occurred at 3:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward Foo, M.D.
ADDRESS (Street, city or town, state): 211 N. Union Ave., Havre de Grace, Md.
DATE SIGNED: 10/22/57
PHYSICIAN'S NAME (Type): Edward C. Foo, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 24, 1957
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Wooden Jr.
ADDRESS: Abingdon, Md.
24a. REC'D BY REGISTRAR DATE: OCT 28 1957
24b. REGISTRAR'S SIGNATURE: Dr. A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

## CERTIFICATE OF DEATH

10730

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madonna
c. LENGTH OF STAY IN 1b 60yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madonna x2
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NELSON Middle G Last SMITH

4. DATE OF DEATH Month Oct Day 21st Year 1957

5. SEX M

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct 13-1884

9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months 0 Days 2 IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor

10b. KIND OF BUSINESS OR INDUSTRY Bethel Church

11. BIRTHPLACE (State or foreign country) Cockeysville Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ignatius G Smith

14. MOTHER'S MAIDEN NAME Laura Tittle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-32-0985A

17. INFORMANT David V. Smith Address White Hall Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, Acute. — INTERVAL BETWEEN ONSET AND DEATH 3 Hr's.

420.1

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROTIC - HYPERTENSIVE HT. DISEASE — 10 years.

DUE TO (c) CORONARY SCLEROSIS — 10 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17/ 1954 to 10/16/ 1957 that I last saw the deceased alive on 10/14/ 1957 and that death occurred at 6:40 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE S. James Thomison Jr. M.D. ADDRESS (Street, city or town, state) Jarrettsville, Md DATE SIGNED 10/23/57

PHYSICIAN'S NAME (Type) S. JAMES THOMISON, Jr., M. D. Jarrettsville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct 24-57

22c. NAME OF CEMETERY OR CREMATORY Mt Joy

22d. LOCATION (City, town, or county) (State) Fraser Rd Monkton Md

23. FUNERAL DIRECTOR'S SIGNATURE Marshall E Rickard ADDRESS Jarrettsville Md

24a. REC'D BY REGISTRAR DATE 10-26-57

24b. REGISTRAR'S SIGNATURE Priscilla Foxwood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10721

## CERTIFICATE OF DEATH

Reg. Dist. No. 10731 185

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville, 07x2.2
d. STREET ADDRESS: Box 214
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Norman Middle Tracy Last Stecher Jr.

4. DATE OF DEATH: Month October Day 31 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1956

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Norman Tracy Stecher

14. MOTHER'S MAIDEN NAME: Vivian Burger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Norman T. Stecher, Perryville, Md. R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tracheo Bronch. X.S — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
501 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Virus Pneumonia — 4 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 492 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 24, 1957, to Oct 31, 1957, that I last saw the deceased alive on Oct 31, 1957, and that death occurred at 6.35 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. H. Richards Jr. M.D.
ADDRESS (Street, city or town, state): P.O. Box. 7 Md
DATE SIGNED: 11-1-57

PHYSICIAN'S NAME (Type): G. H. Richards Jr. Port Deposit - md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-3-1957
22c. NAME OF CEMETERY OR CREMATORY: Hopewell cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis Patterson & Son, Perryville, Md.
ADDRESS

24a. REC'D BY REGISTRAR DATE 11-1-57
24b. REGISTRAR'S SIGNATURE: A. L. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The blue copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10732

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

10736

# CERTIFICATE OF DEATH

Reg. Dist. No. 182

**1. PLACE OF DEATH**

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks

LENGTH OF STAY (in this place): 5

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE: Maryland COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks

STREET ADDRESS (If rural give location):

**3. NAME OF DECEASED** (Type or Print): Mary (First) Josephine (Middle) Sweeting (Last)

**4. DATE OF DEATH**: October (Month) 17, (Day) 19 57 (Year)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Sept. 3, 1869 | 88 yrs. | 1 | 14 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Cherry Hill Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Benjamin Rigdon | Nancy Rigdon |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|
| No | | Mrs. Mary Bosley Rocks Md. |

**18. MEDICAL CERTIFICATION**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x

IMMEDIATE CAUSE (A): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B): Generalized arteriosclerosis — Approx. 20 years

DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Deafness — Unknown.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

**22. I hereby certify** that I attended the deceased from Nov. 19, 1952, to Oct. 17, 1957, that I last saw the deceased alive on Oct. 15, 1957, and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE: Robt Barthel M.D. — ADDRESS (Street, city, town, state): Forest Hill, Maryland — DATE SIGNED: 10-17-57

| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 19-57 | Emory church | Emory, Harford, Md |

| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS |
|---|---|---|
| DATE 10-21-57 | Priscilla Foxwood | Martin Gehrt Jarrettsville Md |

1/24

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10737 **CERTIFICATE OF DEATH** 10733

Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Leonard Middle E. Last Thompson

4. DATE OF DEATH Month Oct Day 3 Year 1957

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 15, 1903

9. AGE (In years last birthday) 54 yrs.

IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) Grayson Co. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Geo Thompson

14. MOTHER'S MAIDEN NAME Matilda Frame

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give dates of service)

16. SOCIAL SECURITY NO. 218-18-1012

17. INFORMANT Mrs Leonard Thompson Address Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 wks

DUE TO (b) Arterio-sclerotic C-V Disease — 7 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1957, to Oct, 1957, that I last saw the deceased alive on Oct 5, 1957, and that death occurred at 1 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE J. Ralph Hurley M.D. ADDRESS (Street, city or town, state) Churchville Md DATE SIGNED Oct 16

PHYSICIAN'S NAME (Type) J. Ralph Hurley MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Oct. 10, 1957

22c. NAME OF CEMETERY OR CREMATORY Bel-Air Memorial

22d. LOCATION (City, town, or county) Park (State) Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey ADDRESS Darlington, Md.

24a. REC'D BY REGISTRAR DATE Oct 9, 1957

24b. REGISTRAR'S SIGNATURE C. H. Kirk

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10722

10734

Reg. Dist. No. 185

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 8 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dea Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS R.D. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Thomas Middle Tibbs Last
4. DATE OF DEATH Month October Day 11 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 20 April 1949
9. AGE (In years last birthday) 8 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. Robert Tibbs Sr.
14. MOTHER'S MAIDEN NAME Mildred Walter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. *** *** ***
17. INFORMANT J. Robert Tibbs Sr. Address R.D. 1 Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.S.W. Chest — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
919.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Accidentally shot by brother
20c. TIME OF INJURY Hour 5 p. m. Month, Day, Year 10-11 1957
20d. INJURY OCCURRED While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Harford (County) Havre de Grace (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER [ ] Bel Air, Md.
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type) Gerald E Palmer MD
DATE SIGNED 10-12-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/15/57
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion
22d. LOCATION (City, town, or county) R.D. Bel Air, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring
ADDRESS Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE 10-15-57
24b. REGISTRAR'S SIGNATURE G. L. Ohnsorg

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

10738

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 5 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital Aberdeen Proving Ground

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Edgewood
d. STREET ADDRESS: 1 g E Ceder Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle JOSEPH — Last TROPEA

4. DATE OF DEATH: Month October — Day 30 — Year 1957

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 30 Oct 57

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 2 — Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Frank Tropea

14. MOTHER'S MAIDEN NAME: Shizuko Hara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: (Same as in 2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature Birth — INTERVAL BETWEEN ONSET AND DEATH: —
776x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. p. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 30 October, 19 57, to 30 Oct, 19 57, that I last saw the deceased alive on 30 October, 19 57, and that death occurred at 2145 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph M. Silverstein M.D.

ADDRESS (Street, city or town, state): US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md

DATE SIGNED

PHYSICIAN'S NAME (Type): JOSEPH M SILVERSTEIN CAPT MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/4/57

22c. NAME OF CEMETERY OR CREMATORY: A.C.C Post Cemetery

22d. LOCATION (City, town, or county) (State): Army Chemical Center, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Tarring

ADDRESS: Aberdeen Md

24a. REC'D BY REGISTRAR DATE: Nov 2-57

24b. REGISTRAR'S SIGNATURE: Millie K. Perry

2050282XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10723

10736 185
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace DOA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Janet — Middle: — Last: Walter

4. DATE OF DEATH: Month: October — Day: 18 (19) — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 14 - 1957

9. AGE (In years last birthday): 27 days

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Walter

14. MOTHER'S MAIDEN NAME: Mildred Shumater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harry Walter — Address: Havre de Grace Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary hemorrhage
771.0
DUE TO (b): unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air, Md — DATE SIGNED: 10-19-57

EXAMINER'S NAME (Type): Gerald C Palmer MD — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-20-1957

22c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

22d. LOCATION (City, town, or county) (State): Elkton, Cecil Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jasper R Grant — ADDRESS: North East, Md

24a. REC'D BY REGISTRAR — DATE: OCT 22 1957

24b. REGISTRAR'S SIGNATURE: Dr. A L Lewis

VS. A15ME
5M 2/57

207275 XV5

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10739 10737

Reg. Dist. No. 181

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Salvage Area APG

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa — b. COUNTY: Lancaster
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Palmyra 75x-3
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: Eugene — Last: Wolfe

4. DATE OF DEATH: Month: October — Day: 15 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 18, 1926

9. AGE (In years last birthday): 30 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Scrap Dealer

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Wolfe

14. MOTHER'S MAIDEN NAME: Mary Kreiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1945-1947

16. SOCIAL SECURITY NO.: 163-22-0349

17. INFORMANT: Address: Raymond Wolfe

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushing injury Chest — INTERVAL BETWEEN ONSET AND DEATH

910.3

DUE TO (b):

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Part of aircraft he was working on fell on him

20c. TIME OF INJURY: Hour: 3 p. m. — Month, Day, Year: 10-15 1957

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Salvage area

20f. (City or town): APG — (County): Harford — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

Bel Air, Md DATE SIGNED 10-16-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/19/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county): Fredericksburg (State): Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garvin — ADDRESS: Aberdeen Maryland

24a. REC'D BY REGISTRAR DATE: Oct 17/57

24b. REGISTRAR'S SIGNATURE: Nellie R Perry

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10724 — 10738 — Reg. Dist. No. 182

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Emmorton Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: 1 Emmorton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Millard — Middle: Filmore — Last: Wright
4. DATE OF DEATH: Month: October — Day: 30 — Year: 19 57
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 27 - 1863
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Springfield, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert J Wright
14. MOTHER'S MAIDEN NAME: Sallie Perkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs Sadie W. Stephenson, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Oedema — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Bruise Skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
904.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell + struck head
20c. TIME OF INJURY — Hour: 7 a.m. — Month, Day, Year: 10-16 19 57
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — Bel Air, Md — DATE SIGNED: 10-30-57
EXAMINER'S NAME (Type): Gerald C Palmer MD — Harford Co.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-1-57
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Episcopal
22d. LOCATION (City, town, or county) Emmorton Harford (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph T Foster Bel Air, Md.
24a. REC'D BY REGISTRAR DATE: 10-31-57
24b. REGISTRAR'S SIGNATURE: Priscilla Fonwood

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10725

## CERTIFICATE OF DEATH

10739 185

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE

c. LENGTH OF STAY IN 1b: 3 Mo.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FALLSTON X O

d. STREET ADDRESS: BOX 116

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: FRANCES — Middle: A. — Last: WYKES

4. DATE OF DEATH: Month: OCTOBER — Day: 7 — Year: 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 19, 1876

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: ____ Days: ____

IF UNDER 24 HRS.: Hours: ____ Min.: ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MISSOURI Kansas City

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: MORRIS RUSSELL

14. MOTHER'S MAIDEN NAME: HONORE RUSSELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs Ione Harvey, Fallston. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-5, 1957, to 10-7, 1957 that I last saw the deceased alive on 10-5, 1957, and that death occurred at 12:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — ADDRESS (Street, city or town, state): Bel Air, Md. — DATE SIGNED: 10-7-57

PHYSICIAN'S NAME (Type): Gerald C Palmer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 10, 1957

22c. NAME OF CEMETERY OR CREMATORY: Odell Protestant

22d. LOCATION (City, town, or county) (State): Odell Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: W H Archer — ADDRESS: Benson Md

24a. REC'D BY REGISTRAR DATE: OCT 8 1957

24b. REGISTRAR'S SIGNATURE: Dr A. L. Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55